**MDL 3079, *In Re: Tepezza Marketing, Sales Practices, and Products Liability Litigation***

# Plaintiff Profile Form

In completing this Plaintiff Profile Form, you are under oath and must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

## I. Case Information

Caption: _____

Date filed: _____

Court and Docket No.: _____

Plaintiff's attorney and contact information: _____

## II. Plaintiff Information

Name: _____

Spouse: _____

Address: _____

Date of birth: _____

Social Security No.: _____

## III. Diagnosis & Treatment

Plaintiffs reserve the right to supplement and amend.

1. Date of Diagnosis of Thyroid Eye Disease and/or Graves Orbitopathy: _____

2. Name and address of health care provider(s) who diagnosed above condition(s):

_____

3. Name and address of healthcare provider(s) who prescribed TEPEZZA:

_____

4. For each round of TEPEZZA infusions administered:

   a. Total number of infusions: _____

   b. Date of first infusion: _____

   c. Date of last infusion: _____

   d. Date(s) of other infusions: _____

5. Name and address(es) of medical facility where TEPEZZA infusions were administered:

_____

6. Describe any injuries or symptoms you allege are related to TEPEZZA and identify any healthcare providers providing treatment for the injuries or symptoms, and the approximate date(s) of the treatment(s).

| Symptom | Yes/No | Bilateral or Unilateral | Provider Name and Address | Approximate Date of Diagnosis and period(s) of treatment |
|---|---|---|---|---|
| Hearing loss | | | | |
| Tinnitus | | | | |
| Meniere's Disease | | | | |
| Eustachian tube dysfunction | | | | |
| Hyperacusis | | | | |
| Hypoacusis | | | | |
| Autophony | | | | |
| Other [*identify*] | | | | |

## IV. Medical History

1. Prior to the first infusion of TEPEZZA have you ever been diagnosed with diseases or disorders of the ear, including those listed in question 6, subsection III?

Yes ☐ No ☐

**If yes,** please provide the approximate date(s) of diagnosis for each condition, and the name and address(es) of the health care provider(s) who made the diagnosis.

_____

2. Prior to the first infusion of TEPEZZA have you ever:

a. Had a head injury?

Yes ☐ No ☐

**If yes**, provide date of diagnosis and provider name and address:

_____

b. Worn a hearing aid?

Yes ☐ No ☐

**If yes**, provide date of diagnosis and provider name and address:

_____

c. Had your hearing tested?

Yes ☐ No ☐

**If yes**, provide dates and provider name and address:

_____

d. Used oral hormone therapy?

Yes ☐ No ☐ Don't recall ☐

**If yes**, provider name and address: _____

**If yes**, duration of therapy: _____

e. Been exposed to loud noises (including, but not limited to, concerts, construction, motorcycle engine and shot gun blast)?

Yes ☐ No ☐ Don't recall ☐

**If yes,** for how long? _____

f. Smoked?

Yes ☐ No ☐

**If yes,** how much and for how long? _____

3. Do you have a family history of hearing loss?

Yes ☐ No ☐ Don't know ☐

**If yes,** provide details _____

## V. Primary Care Physicians

Please provide a list of all your treating physicians for ten years prior to your first infusion with TEPEZZA, including all primary care physicians, endocrinologists, ophthalmologists, otolaryngologists, audiologists, and hearing instrument specialists. For each, provide name, address, and approximate period of treatment.

| Name of Provider | Address | Approximate period(s) of treatment |
|---|---|---|
| | | |
| | | |
| | | |

## VI. Pharmacies

Please provide a list of all pharmacies where you filled prescriptions for ten years prior to your first infusion with TEPEZZA. For each, provide name, address, and approximate dates.

| Name of Pharmacy | Address | Approximate period(s) |
|---|---|---|
| | | |
| | | |
| | | |

## VII. Medications

1. Before your first infusion with TEPEZZA, had you ever taken:

   a. Antibiotics such as gentamicin
   Yes ☐ No ☐ Don't recall ☐

   b. Anticancer medicines, such as cisplatin (Platinol) and carboplatin (Paraplatin)
   Yes ☐ No ☐ Don't recall ☐

   c. Pain medications that contain salicylate, such as aspirin, quinine, and loop diuretics
   Yes ☐ No ☐ Don't recall ☐

   d. Cardiac medications
   Yes ☐ No ☐ Don't recall ☐

   e. Medications to treat high blood pressure
   Yes ☐ No ☐ Don't recall ☐

   f. Medications to treat diabetes
   Yes ☐ No ☐ Don't recall ☐

   g. Non-steroidal anti-inflammatory drugs (NSAIDS)
   Yes ☐ No ☐ Don't recall ☐

## VIII. Employment and Disability Claims

1. Please provide the following information about your employment history for ten years prior to the date of your first infusion: Employer name, address(es), job title/description of duties/and approximate dates of employment.

| Name of Employer | Address | Job title/brief description of duties | Approximate dates of employment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

2. Have you applied for workers' compensation, Social Security disability (SSI or SSD) benefits, or other state or federal disability benefits within the past 10 years?

Yes ☐ No ☐

**If yes,** please specify the date(s) of application, the type of benefits sought; the agency from which you sought benefits; the nature of the claimed injury/disability; and whether the claim was accepted or denied.

_____

_____

_____

## IX. Authorizations and Medical Records

1. For each provider or pharmacy identified on this Profile Form, provide a completed and signed Authorization for Release of Records in the form attached as Exhibit A to Case Management Order No. 3.

2. To the extent you are asserting a claim or intend to assert a claim for economic loss and/or wage loss as a result of your TEPEZZA infusions, please check boxes for employment records and Worker's Compensation records in the Authorization for Release of Records in the form attached as Exhibit A to Case Management Order No. 3 and provide a completed and signed Consent for Release of Information (SSA-3288) attached as Exhibit B to Case Management Order No. 3.

3. To the extent you are asserting a claim or intend to assert a claim for psychiatric and/or psychological injuries beyond standard emotional-distress damages in a personal-injury context as a result of your TEPEZZA infusions, please check the boxes for release of psychiatric and mental-health records in the Authorization for Release of Records in the form attached as Exhibit A to Case Management Order No. 3.

4. Please produce the medical records of the healthcare providers identified above and any other of the Plaintiff's medical records that are in your possession or your counsel's possession as of the date this PPF is executed.

## VERIFICATION

I, _____, declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Profile Form and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____ _____

Date Signature of Plaintiff